Bureau Talk

Missouri Department of Health and Senior Services
Unit of Home Care and Rehabilitative Standards

Volume 03-3 – December 2003

THIS INFORMATION SHOULD BE DIRECTED TO THE MANAGEMENT STAFF OF YOUR AGENCY

New Name

You will notice a name change on correspondence received from us in the future due to reorganization in the Department. We are now a unit within the Bureau of Health Care Oversight. We will continue to answer the telephone as Home Care and Rehabilitative Standards.

Important Notice

All home health agencies with approved branch locations have received notification of their branch identification numbers.

Any OASIS assessment completed by a branch MUST contain the CMS issued branch ID number on and after January 1, 2004, or the home health agency will receive a fatal error and the information will be rejected. The branch identification number should be entered on OASIS item MO016. If the agency has no branches, enter "N". If the assessment was performed by the home office (parent) of an agency which has branches, enter "P". Refer to page 8.16 of the OASIS Implementation Manual for further instructions for completion. If you have questions about your branch ID numbers, contact Linda Grotewiel at our office (573/751-6336). If you have questions regarding the OASIS assessment, contact Mike DeClue at 573/751-6308.

The Collection and Transmission of OASIS Data for Private Pay Patients (non-Medicare/non-Medicaid)

On December 8, 2003, the President of the United States signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MPDIMA), which temporarily suspends the collection of OASIS data on non-Medicare/non-Medicaid patient of an home health agency. During this temporary suspension, CMS will conduct a study on how OASIS information on these patients is and can be used by large HHAs and examine whether there are unique benefits for the analysis of this information that cannot be derived from other information available to, or conducted by, these HHAs. Additional studies will also be conducted. The results of the studies will determine future CMS requirements regarding the collection of OASIS data as part of each patient's assessment. Until that time:

HHAs must continue to comply with the aspects of the regulation at 42 CFR 484.55 regarding the comprehensive assessment of patients. The agency must provide each agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical,

nursing, rehabilitative, social, and discharge planning needs.

HHAs may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use.

HHAs must continue to collect, encode, and transmit OASIS data for their non-maternity Medicare and Medicaid patients that are age 18 and over and receiving skilled services. CMS is defining private pay patients to include any patient for whom (MO150) the Current Payment Source for Home Care is NOT one of the following:

1- Medicare (Traditional fee-for service)
2- Medicare (HMO/managed Care)
3- Medicaid (Traditional fee-for service)
4- Medicaid (HMO/managed care)

If a patient has private pay insurance and MO150 response is 1, 2, 3, or 4 as an insurance to whom the agency is billing the services, the comprehensive assessment including OASIS must be collected and transmitted.

Remember the term Medicare (HMO/managed care) does include Medicare +Choice (M+C) plans and Medicare PPO plans.

FOR YOUR INFORMATION

The FDA has alerted healthcare professionals of several reports of toxicity, including death, associated with the use of FD&C Blue No. 1 (Blue 1) in enteral feeding solutions. In these reports, Blue 1 was intended to help in the detection and/or monitoring of pulmonary aspiration in patients being fed by an enteral feeding tube. Reported episodes were manifested by blue discoloration of the skin, urine, feces, or serum and some were associated with serious complications such as refractory hypotension, metabolic acidosis and death. Case reports indicate that seriously ill patients, particularly those with a likely increase in gut permeability (e.g., patients with sepsis), may be at greater risk for these complications.

You may access the MedWatch 2003 safety summary, including links to the full Center for Food Safety and Applied Nutrition (CFSAN) Public Health Advisory, at: http://www.fda.gov/medwatch/SAFETY/2003/safety03.htm#FDCblue

THE FOLLOWING QUESTION WAS RECENTLY RAISED WITH CMS: When surveyors arrive in a facility, does the facility need to track everything that surveyors review regarding clients under the HIPAA requirements for privacy?

The clarification received from the Office of Civil Rights is as follows:

HIPAA requires that "covered entities (CE)" keep track of any access to medical records that they retain because at any time an individual or his/her personal representative can demand an "accounting" from the CE about all disclosures that have been made. That having been said, this record keeping need not be burdensome. Since the files have been identified by the surveyors, one method would be a simple statement that is manually or electronically (or both) put in each file stating that "State Surveyors had access to medical records for persons who were patients of (agency name) during the time period (dates). This access was provided on (dates). Purpose was to _____.

OPT Providers:

Cahaba recently released a clarification regarding the coverage and billing of occupational therapy (OT) driving evaluations. A one-time driving evaluation would not be a Medicare benefit *unless* that evaluation is part of a plan of care for further treatment of the disability resulting from a medical condition.

A driving evaluation may be covered when it is part of an assessment to determine the patient's level of functioning and to establish a treatment

plan in which the goals would reflect the expected outcomes. Medical necessity must be well documented in the medical record.

If it is medically necessary for OT to do a driving evaluation, Medicare will only pay for the portion of the evaluation performed in the outpatient department. Medicare would not pay for the therapist to actually go for the car ride with the beneficiary. Driving evaluations will be denied if the only reason for the evaluation is to determine a patient's driving capabilities. (Refer to Medicare A Newsline – October 1, 2003)

HOSPICE

⇒⇒Bereavement Assessments:
Clarification has been requested regarding bereavement assessments and if they must be completed in the home. The expectation is that bereavement assessments will be completed during a visit to the bereaved and not by telephone.

⇒⇒Billing:
Remember hospice patients cannot be billed for items that should be covered under the hospice benefit. An example would be: The hospice patient resides in a nursing facility. The nursing facility bills the hospice patient for room and board, supplies, etc., in addition to medications, supplies etc., that are the responsibility of the hospice. The hospice patient pays the entire bill and then the hospice reviews the bill for their responsibility and reimburses the nursing facility. The nursing facility then gives the hospice patient credit on the next month's bill.

This is not an acceptable practice and is a violation of the provider agreement Section 1866 of the Social Security Act.

⇒⇒Revocation and Discharge:
Please take time to review the difference in revocation and discharge of hospice patients. Revocation is the patient's choice **not** the hospice's.

Nurses Allowed to Carry Alteplase

Effective the end of September, the State Board of Pharmacy rule has been amended. 4 CSR 220-2.010 Pharmacy Standards of Operation, has been amended regarding home care nurse drugs and will allow the nurses to carry Alteplase. The amended rule states:

(8) a home health or hospice agency licensed or certified according to Chapter 197, RSMo, or any licensed nurses of such agency, may possess drugs in the usual course of business of such agency without being licensed as a pharmacist or pharmacy.

(A) The list of drugs that may be possessed by a home health or hospice agency without a license or permit, as defined in section (8), is as follows:

1. Injectable dosage forms of sodium chloride; and water;
2. Irrigation dosage forms of sodium chloride and water that carry a federal prescription only restriction;
3. **Injectable dosage forms of heparin and alteplase in concentrations that are indicated for maintenance of venous access devices;**
4. Injectable dosage forms of diphenhydramine and epinephrine;
5. Vaccines indicated for public health needs, such as influenza, pneumonia, hepatitis A and hepatitis B; and
6. Tuberculin test material.

(D) When the patient or the patient's representative has been instructed, verbally and in writing, in the performance of routine care procedures, up to a two (2) week supply of sodium chloride, water and heparin, may be left with the patient for these procedures. Drugs left with the patient shall be labeled with instructions for use. A record shall be made of all drugs left with the patient in the patient's medical record. Drugs left with the patient may not be returned to the agency.

Required Alzheimer's Training for Those Employed by Home Health

Below is a copy of the Section of RSMo 660.050 that addresses dementia specific training requirements. For a complete copy of Chapter 660, Section 660.050 refer to: http://www.moga.state.mo.us/STATUTES/C660.HTM.

8. The division shall, by January 1, 2002, establish minimum dementia-specific training requirements for employees involved in the delivery of care to persons with Alzheimer's disease or related dementias who are employed by skilled nursing facilities, intermediate care facilities, residential care facilities, agencies providing in-home care services authorized by the division of aging, adult day-care programs, independent contractors providing direct care to persons with Alzheimer's disease or related dementias and the division of aging. Such training shall be incorporated into new employee orientation and ongoing in-service curricula for all employees involved in the care of persons with dementia. The department of health and senior services shall, by January 1, 2002, establish minimum dementia-specific training requirements for employees involved in the delivery of care to persons with Alzheimer's disease or related dementias who are employed by home health and hospice agencies licensed by chapter 197, RSMo. Such training shall be incorporated into the home health and hospice agency's new employee orientation and ongoing in-service curricula for all employees involved in the care of persons with dementia. The dementia training need not require additional hours of orientation or ongoing in-service. Training shall include at a minimum, the following:

(1) For employees providing direct care to persons with Alzheimer's disease or related dementias, the training shall include an overview of Alzheimer's disease and related dementias, communicating with persons with dementia, behavior management, promoting independence in activities of daily living, and understanding and dealing with family issues;

(2) For other employees who do not provide direct care for, but may have daily contact with, persons with Alzheimer's disease or related dementias, the training shall include an overview of dementias and communicating with persons with dementia.

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What we expect to see on a Plan of Correction:

We continue to see problems with Plan of Correction. Please read the letter that accompanies each statement of deficiencies. This letter clearly outlines the information that must be contained in your Plan of Correction. The plan should include how each of the deficient practices identified will be corrected (not each record but each deficiency), the systemic changes to be made, what will be done to monitor the effectiveness of the changes, an overall completion date and who, by position, not name, will be responsible for monitoring the correction to prevent its recurrence. Even though the deficiency may have been corrected before the plan of correction is returned to our office, you must outline your plan of correction. The word "Corrected" or "Completed" is not an acceptable response.

Remember you must sign and date BOTH the state and federal Statement of Deficiencies prior to submitting them to our office.

In an effort to conserve state funds we are publishing fewer Bureau Talks. We will disseminate information by use of e-mail and our website. PLEASE be sure the office has a current e-mail address for your agency's administrator. Our website will be updated with new information as it becomes available to us. You can access our website at http://www.dhss.state.mo.us/Home_Health/

All information required for starting an agency or for a change of ownership is now on the Unit website. You can download this information free of charge or fill out the order form available on the website and send it with the required fee to the Unit and a packet will be mailed to you.

Advisory Councils

New members have been appointed to the Home Health Advisory Council. We appreciate the time the members of the both the Home Health and Hospice Advisory Councils give. If you have concerns or questions pertaining to either program, you may contact our office or any of the council members.

Hospice Advisory Council Members:

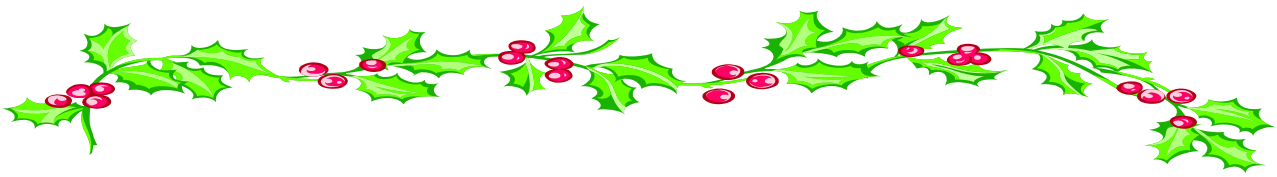
- Mary Dyck – Riverways Hospice
- Elaine McIntosh – Kansas City Hospice
- Susan O'Kane – AMHeart Hospice
- Jim Pierce – Hands of Hope Hospice
- Audrey Ryan – SSM Hospice

Home Health Advisory Council Members:

- LuAnn Meyer – Pike County Home Health and Hospice
- Carol Cronkite – Visiting Nurse Association
- Marcia Eckrich – Lutheran Senior Services Home Health
- Angela Littrell – Boone Hospital Home Care
- Paul Reinert – Integrity Home Care
- Gloria Metzger – Consumer
- Erma Cunningham – Consumer
- Marcia Dampf – Consumer
- Fern Dewert – Unit Representative

Note from Linda Grotewiel, Administrator

Effective January 15, 2004, Lisa Coots, R.N., will assume the position of Interim Administrator for the Unit of Home Care and Rehabilitative Standards as I will be leaving the Department. I have enjoyed and appreciated the respect and cooperation we share with the provider industry and know that Lisa and the entire unit will continue this relationship. It has been my privilege to work with providers that have such a tremendous impact on the health care of the citizens of Missouri. Thanks to all of you for the jobs you do. Good-bye and continued success.



Wishing Everyone a Happy New Year